

FIS 0320 (10/06) Office of Financial & Insurance Services

File with your quarterly and annual statements. Provide data based on calendar year.

DUE
quarterly

Name of HMO	NAIC Group number and Co. code
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Indicate ☐ 2006 Annual data DUE March 1, 2007
which ☐ Q1 data DUE May 15, 2007
report you ☐ Q2 YTD DUE August 15, 2007
are filing. ☐ Q3 YTD DUE November 15, 2007

Section 1-Contracted Hospitals *Attach additional sheet(s) if necessary.*

Name of contracted hospital

Total number of Inpatient Discharges

Elective

Emergency

Total

Subtotals:

Name of NON-Contracted hospital	Total number of Inpatient Discharges		
	Elective	Emergency	Total
Subtotals:			

	Elective Inpatient Discharges from Contracted Hospitals	Elective Inpatient Discharges from NON-Contracted Hospitals	TOTAL Elective Inpatient Discharges from Contracted AND NON-Contracted Hospitals
Number of Discharges			
Percentage of Discharges	%	%	100%
Enter amount (in dollars) of 3 month projected incurred claims from non-contract hospitals			\$

	Total Benefit Payout	Percentage of Payments
Total payments to contracted providers	\$	%
Total payments under Hospital Access Agreement (Medicaid only)	\$	%
Total payments to non-contracted providers	\$	%
Total medical and hospital expenses paid	\$	100%

1. Does the HMO have medical malpractice or managed care errors and omissions coverage? ☐ Yes ☐ No *If yes, please complete below:*

Name of carrier	Limits of coverage	Expiration date

Signature	Date signed	Person and phone number to contact regarding this report
Signer's name and title typed or printed		



Michigan Department of
Labor & Economic Growth

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